STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155631	A. BUILDING 00 B. WING	06/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE RIVER LODGE LTD	3710 KENNY SIMPSON LN BEDFORD, IN47421

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F0000	This visit was for the Investigation of Complaint IN00092855. This visit resulted in a partially extended survey-immediate jeopardy. Complaint IN00092855 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323. Survey dates: June 29 and 30, 2011 Facility number: 001153 Provider number: 155631 AIM number: 200155900 Survey team: Marla Potts, RN, TC Melinda Lewis, RN Census bed type: SNF/NF: 55 Residential: 9 Total: 64 Census payor type: Medicare: 3 Medicaid: 47 Other: 14 Total: 64 Sample: 3	F0000	Preparation and execution of the plan of correction for the survey does not constitute admission of agreement by this provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by the Federal and State law. This provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of its residents; nor are they of such character as to limit the provider's capacity to render adequate resident care. This plan of correction serves as the facility's written credible allegation that it will be in substantial compliance on or before July 12, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	This deficiency also reflects state findings in accordance with 410 IAC 16.2. Quality review 7/05/11, by Suzanne Williams, RN			
F0323 SS=J	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure residents who smoke were supervised regarding their whereabouts, were safe to smoke independently and were provided with a safe place to smoke, resulting in residents having to leave facility property and sit and smoke on the city street in front of the facility, without sidewalks or lighting and without staff monitoring their coming and going to assure their safety and resulting in a resident smoking outside while wearing oxygen, for 2 of 2 smokers who were admitted after the new smoking policy took affect, in the sample of 3 residents (Residents B and C) The Immediate Jeopardy began on 5/22/11 when Resident B started smoking outside, was told she had to leave facility property in order to smoke, and was found outside smoking while wearing oxygen. The Administrator and Director of Nursing were notified of the Immediate	F0323	The facility does ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Facility systems, policies and protocols have been reviewed and are appropriate.The facility does wish to IDR this citation.The facility became smoke free on February 1, 2011 in accordance with the Indana Clean Air Act (Indiana Code 16-41-37). The policy applied to residents admitted after February 1, 2011. Residents B and C were aware of the policy on admission. Resident B's desire to smoke on the premises does not obligate the facility to conform to the wishes of Resident B.There was no accident or incident resulting in any injury. As part of the abatement plan, Residents B and C were permitted to smoke on facility grounds in the designated area effective June 29, 2011.1. Resident B had in fact been assessed at her home for	07/13/2011

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	Jeopardy at 1:37 P.M. on 6/29/11. The Immediate Jeopardy was removed on 6/30/11, but noncompliance remained at no actual harm, with potential for more than minimal harm, that is not immediate jeopardy. Findings include 1. During interview with Resident B on 6/29/11 at 8:30 A.M., she indicated she had to smoke in the street and knew the facility was non smoking prior to admission. Resident B indicated she was surprised that she could not smoke in the front parking lot or outside. Resident B indicated at 12:00 P.M. this same day, she had a lot of concerns with smoking at night, and that was her usual time to smoke. She indicated she worried about getting hit on the street because people speed along. She indicated she had reflectors on her chair but was afraid she would not be seen and the street was narrow. Resident B indicated she had not told anyone about her concerns for her safety because [name of Social Service Director] had been so adamant about going to the street. Resident B indicated she had been very ill when first admitted and had not smoked for a few weeks. Resident B was observed sitting on the side of the road in her electric wheelchair		potential facility admission prior to hospital admission and subsequent facility admission on 4/26/11. She quit smoking in the hospital and decided not to smoke at the facility. She was noted to be smoking on 5/22/11 and staff intervened immediately with education on safety and assuring that resident could safely smoke. This is noted in the clinical record on that day. This was again reviewed on 6/9/11 as noted in the formatted smoking assessment in the clinical record. On 5/25/11, resident was seen by the nurse practitioner as she requested assistance with smoking cessation. An order was received for Nicotine patches to assist her with cessation. On 6/1/11, the order was received from the nurse practitioner to discontinue this order as resident made the choice to continue smoking. The nursing note on 5/25/11 in it's entirety does indicate that a call was placed to resident's sister, Gail, as resident was smoking. The notes continue that the nurse practitioner was also notified at that time and did in fact visit the facility on 5/25/11 at 4:30pm. At that time, she wrote the orders to initiate Nicotine patches.The survey alleges, "the immediate jeopardy began on 5/22/11 when Resident B started smoking outside, was told she had to leave facility property in order to smoke, and was found outside smoking	

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	on 6/29/11 at 1:00 P.M. She indicated she always tried to sit under the shade tree. She indicated Resident C usually smoked in the parking lot of the facility, and was not sure when he had started smoking on the road, too. She indicated he had been smoking in the parking lot for several weeks. LPN #2, Resident B's charge nurse, was interviewed on 6/29/11 at 10:00 A.M. She indicated the resident was typically up more at night and night shift would report to her the resident had normally been out three, four or five times during the night shift hours to smoke, and thought it was four times last night. LPN #2 indicated Resident B had commented it was hard for people to see her on the road. Resident B's clinical record was reviewed on 6/29/11 at 10:30 A.M. Resident B's admission Minimum Data Set [MDS] assessment, dated 4/30/11, indicated an admission date to the facility of 4/26/11. The assessment indicated the resident was alert and oriented, and used a wheelchair for mobility. The preadmission inquiry indicated the resident was a smoker. A smoking assessment, dated 6/9/11, indicated "Resident informed that there is		while wearing oxygen." Resident B made the choice to smoke. She was informed of the smoke free policy prior to admission and acknowledged same to survey team (SOD page 3, paragraph 1). Resident B signed the admission contract and agreed to the terms of admission and facility rules. Resident B's choice to smoke while wearing oxygen, knowing fully the risks of doing so, is not evident of deficient practice and does not constitute immediate jeopardy. There is no evidence that the facility is culpable for the acts of Resident B.The street where the facility is located has light traffic. The street houses 2 churches and the nursing facility. It is not a thoroughfare to another area and is lightly traveled. There is a security light approximately 100 feet from where she parked her chair. In addition, there is a light approximately 45 feet diagonally from her parking area as well as the spotlight on the facility signage less than 10 feet from where she parked her motorized wheelchair. There are an additional 2 security lights in the parking area.The nurse practitioner again spoke with this resident on 6/30/11 regarding smoking cessation. She declined assistance. In addition, resident was educated on notifying staff if she felt the need for supervision or assistance with smoking. She acknowledged understanding of the education offered. This was	

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	no smoking anywhere on facility property. Resident is able to verbalize understanding of policy. Resident is alert and oriented. Long term memory good, resident admits that short term memory poor...has attempted to quit smoking and was not smoking when first admitted but stated she thought she would lose her mind and had began to smoke again. During assessment she was able to turn off oxygen properly, light cigarette and extinguish safely. Needs assistance with opening door to exit and enter facility. Resident is aware that there is no smoking since she was admitted on facility property. She is aware of risks and safety concerns. She will let staff know when going out to smoke. Safety at night was discussed with her and she said that she is going to try to not go out after dark but does plan to get some sort of reflector on her electric wheelchair." The ADON indicated, on 6/29/11 at 11:00 A.M., this was the first smoking assessment. Nurses notes first mentioned smoking with the following entry: "5/22/11 9:48 p.m. Res was noted to be in parking lot smoking with oxygen in place. Pt education provided concerning unsafe smoking. instructed to turn off oxygen and walk away from power chair if she feels she has to smoke, offered nicotine		completed and documented in the clinical record on 6/29/11.The survey states that Residents were not supervised regarding their whereabouts. There is no evidence that the facility was not reasonably aware of the resident whereabouts, considering known behavior patterns, or that it was necessary due to significant impairments to know the precise whereabouts of the resident at all times. Given the abscence of this fact, the assertion of lack of supervision is not supported by examples cited. "Resident B indicated that she had not told anyone about her concerns for her safety because the SS Director had been so adamant about going to the street." Resident B's assertion that she was concerned about traffic is not a factual basis that she was actually at risk, as she never informed anyone (outside the social worker who appropriately reaffirmed facility rules) the facility had no culpability. Resident B's claim of fear is self serving and is not evidence of any risk. It is fair to note that she opted to smoke at night despite any concern she may have had for her safety. Her fear was not sufficient to keep her from smoking, nor did she feel compelled to raise the issue with staff persons. She had not raised any concerns prior to being interviewed by surveyor. Resident B "needs assistance with opening the door to exit and	

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	patch...." A nurse's note, dated 5/25/11 at 11:20 a.m. indicated, "call to discuss resident observed smoking across the street, concern for safety if not managing oxygen each time and turning it off, fall risk...." A note dated 6/9/11 at 6:48 A.M. indicated, "Resident went outside at front of building at least twice to smoke and was seen one of those times smoking in fire lane circle drive (driveway of facility)." Nurses notes also indicated: "witnessed fall, 5/14/11 9 a.m. location outside...was walking...roommate outside too...immediate intervention; have resident ask for assistance when outside...." The care plan, dated 4/26/11, included a problem of "Potential for uncontrolled bleeding and/or prone to bruise easily due to coumadin (blood thinning medication) therapy" and "Potential increased respiratory difficulty", approaches included Oxygen at 3.5 liters per nasal cannula. Another problem, dated 5/3/11, indicated "Potential for Injury trauma, related to new environment, respiratory, weakness, multiple psychiatric medications...."		enter the facility", (SOD page 4, paragraph 4). Subsequently, staff were aware of her whereabouts.On "5/22/11 at 9:48 p.m., Resident B was noted in the parking lot with oxygen in place." When observed, staff immediately provided education regarding the risks of smoking with oxygen nearby, but there is no affirmation in the SOD or in the clinical record that the oxygen was turned on. Subsequently, this is not evidence of non-compliance at the level of immediate jeopardy. Safe smoking practices were reaffirmed with this resident on 6/9/11 as noted in the smoking assessment in the clinical record.At no time did the facility identify significant change in Resident B's ability to move about safely in her chair as she had done when she resided in the community in the weeks prior to admission. Resident B was fully aware, and verbalized her understandings of the risks of smoking while using oxygen. The facility exercised prudent efforts, repeatedly informing resident of teh known risks related to her decision to smoke while wearing oxygen. The facility exercised all efforts within it's control, short of removing resident B's smoking materials. Resident B's poor choices are not exemplary of a facility deficient practice at the level of immediate jeopardy.2. Resident C had been erroneously	

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	2. On 6/29/11 at 8:10 A.M., a gentleman smoking a pipe was observed sitting on the an electric scooter at the side of the street, just to the left of the facility parking lot. He was to the left of the facility parking lot. The gentleman identified himself as Resident C, and had an arm band with his name and the facility phone number on his arm. He indicated he had to smoke on the city street because the facility would not allow him to smoke in the parking lot as he had been doing. He indicated (Social Service Director name) and told him yesterday he was not allowed to smoke in the parking lot and had to go to the street. He indicated he had been able to smoke in the parking lot for the past two months but now could not. Resident C indicated he had been told on his admission to the facility he could use the smoke hut in back of the facility, but another resident did things that bothered him and he could not stand to be in the shack because of that resident. Resident C was observed to take a lighter from his pocket and refill his pipe and light it up again. Resident C indicated he hated living at the facility and was going to get out one way or another even if he had to run away. He indicated he would rather have died at home. Resident C was		advised prior to admission that he could smoke in the designated smoke area of the facility. He did not advise staff that he had issues with other residents that accessed the designated smoking area. Resident's admission notes on 4/6/11 do indicate that he has a long history of embellishing tales, which was collaborated by his friend who is also his contact person. His motorized wheelchair is not a car and it is not enclosed, nor is it licensed for use on public roadways. Prior to facility admission, Resident C had been living home alone, but environment was deemed unsafe due to lacking utilities. He is his own person, in the sense that he has no designated power of attorney and no guardian. He makes his own decisions. Resident rights indicate that a resident has the right to make decisions affecting their care and treatment. Those decisions do not have to be in accordance with the plan of care or with care giver beliefs. The decisions reflect the resident choice to leave the facility at will. Resident is aware that he is to sign out of the facility when leaving the property. He chooses not to do this on a regular basis. His belief is that he can do what he wants, which is an aspect of resident rights. As long as he is able and his decisions do not impact others, he can. He chooses to be outside	

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	observed to be outside through 8:30 A.M. Resident C drove his scooter down the side of the street, crossing the entry to the facility and going across a side street to a gate, turning around and then coming back and sitting under a tree on the street in front of the facility. Resident C indicated the staff all smoked in their cars in the parking lot and his scooter was his car so did not understand why he had to sit in the road. He indicated one other resident, a lady, also had to go to the road to smoke. No staff members were observed outside the facility on 6/29/11 or to have checked on the resident. Several cars and trucks were observed to drive by, and a pedestrian walking was observed to pass. Upon entry to the facility at 8:30 A.M. on 6/29/11, the Assistant Director of Nursing indicated she thought Resident C was either in the dining room, his room, or outside smoking in the driveway. When told he was on the city street, she indicated he was his own person and sometimes signed himself out of the facility. The sign out book was checked and Resident C had not signed himself out of the facility. The ADON indicated Resident C was "grandfathered" into the facility (since the new smoking policy) to smoke, and he could smoke in the smoke hut on facility grounds if he wanted to.		and prefers to be outside alone and away from others and this is not deemed as unsafe. Staff was aware that he frequently was out front, but not noted to be smoking. Many times he puts the pipe in his mouth and chews on it without lighting the tobacco. He frequently went onto the roadway with his electric wheelchair "for something to do". A smoking assessment was completed on 4/7/11, the day following his facility admission, and noted that he was safe to smoke without staff supervision. A repeat smoking assessment was completed on 7/4/11 as a quarterly review,and also indicates he is safe to smoke without supervision. On admission, he scored 12 of 15 on the BIMS aspect of the MDS. This indicates some cognitive issues. His specific responses to the 3 words (bed, blue and sock) needed cues to repeat them. This was on initial admit and at a time when he was upset about the change in environment. This triggered the indication of short term memory loss. At no time did he require redirection or guidance to locate his room or other areas of the facility. His ability to understand and move about the property with purpose, direction, and meaning was not in question. The surveyors allegation that the BIMS score indicates risk (culpability) is invlid. This example is not	

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	She indicated Resident B also smoked and went to the city street as she had not been grandfathered into smoking on facility grounds. In an interview with the Assistant Director of Nursing, on 6/29/11 at 9:40 A.M., she indicated the residents who smoked kept their cigarettes and lighters with them at all times unless they required supervision. She indicated there were six residents in the facility who smoked, only one of whom required supervision with smoking (not Resident B or C). Of the six, two had been admitted after the new policy of no smoking on facility grounds took affect, Resident C and Resident B. During interview on 6/29/11 at 8:45 A.M., the Social Service Director indicated she had told Resident C the day before he could not sit in the parking lot and smoke, and knew he was then going to the city street to sit and smoke. Resident C was observed to be sitting under a tree on the city street in front of the facility at 8:45 A.M.; no staff were observed in the parking lot or outside the facility. At 12:40 P.M. this same day, the resident was observed sitting in his electric chair on the side of the street smoking a pipe. The facility was observed on 6/29/11 at 8:10 A.M. to have a street running in the		evidence of a deficient practice or immediate jeopardy. His quarterly review BIMS was completed 7/4/11 and noted a score of 13 of 15, showing no cognitive impairment.The SSD did advise resident he was not to smoke in the parking lot, but did not tell him he had to smoke in the street. He was advised of the designated smoke area. This information had also been shared with him at admission. Resident C told surveyor he was told that he could not smoke on the grounds and had to go to the street. There is no evidence that the social worker told him he had to smoke on the street. Even if this were true, there is no evidence that the location where Resident C was observed posed a risk to him or that it was more or less safe than smoking in the parking lot. Resident admission notes indicate his history of embellishing tales depending on his audience.The surveyor alleges that the facility was unaware of Resident C's whereabouts. The ADON stated that he was "outside smoking in the driveway", but the surveyor reports he was on the "city street." The surveyors description of Resident C's location describes a pattern of movement on the grounds (meaningful and purposeful self pursuit) and fails to describe he was hazardously placing himself in the street. The observation	

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	front of the facility and then a side street which bordered facility property. The facility was set back from this front street with the parking lot, with was a half circle with two entries in between the facility building and the street. Several trees lined both sides of the narrow city street, and no side walks were available by the street. There were three security lights in the parking lot but no street lights. Resident C's clinical record was reviewed on 6/29/11 at 9:00 A.M. Diagnoses included, but were not limited to, diabetes and amputee left leg. The most recent Minimum Data Set [MDS] assessment, dated 4/15/11, indicated the resident was admitted to the facility on 4/6/11, was moderately cognitively impaired, with a deficit in short term memory. The assessment indicated the resident had verbal behavior that affected others. A smoking assessment, dated 4/7/11 at 6:13 P.M., was provided by the Social Service Director on 6/29/11 at 9:00 A.M. She indicated there was not one on the chart and it must still be in the computer. The assessment indicated: "Resident informed that he can only smoke in designated area outside and no other areas on the property or anywhere inside," recall ability - "not consistent." Cognitively status - "alert and oriented to self and		occurred between 8:10am and when the ADON was interviewed at 8:30am. The abscence of Resident C's signature on the sign out book supports the facility assertion that at no time was Resident C at risk. Resident C was moving about on and off the grounds as described in the SOD during the 20 minute window. He clearly had no intent to leve the facility per se. Resident C's decision not to sign out in this case, given the circumstances, is reasonable and prudent. Both residents were contacted by the nurse practitioner on 6/29/11 and offered assistance with a cessation program. Both exercised their rights and declined and documentation was noted in the clinical record. Both residents were also approached regarding staff notification for assistance if they had concerns for their safety. Again, both residents declined any staff assistance while smoking. Both care plans were updated to include staff assistance if resident chooses.The facility immediately notified all staff that were in house on 6/29/11 of changes. All other staff were notified on their return to work. All staff had signed inservice form by 7/6/11 with the exception of 2 staff members who remain on FMLA. They were notified and completed instruction on 7/12/11. In addition, the facility presented an all staff inservce on 7/8/11 that	

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	location." Decision making skills - "can make decisions related to activities of daily living, may make poor choices," "smokes pipe and can hold it independently." Is physically capable of managing smoking materials and smoking safely, "uses an electric wheelchair due to left leg amputated." The care plan included a problem, dated 4/21/11, for "resident is at risk for falls related to history of falls, fluctuation in blood sugars (chooses not to follow prescribed diet) left leg amputation at hip, periods of paranoia and impulsive/poor safety awareness." Another problem, dated 5/10/11, was "Resident displays moderate impairment with cognition as evidenced by score of 12 out of 15 on bims completed 4/15/11. He has potential for poor judgement with some decisions but appears able to make routine decisions." Approaches included: "offer conversation and give reminders as needed when forgetful, assist as needed, praise efforts, report any unsafe observations to nurse." Another problem, dated 5/10/11, indicated "Resident becomes easily angered and displays verbal abuse by using curse words at others when angry...rejects care and will state he does not need it such as medications, treatments or ADLs (activities of daily living) with		included safe driving practices for staff on facility property and in the facility neighborhood as well as for their families who may drive to the faciilty; resident rights with specific regards for choices to decline assistance and following plan of care; residents signing themselves out of facility, as well as notification of supervisory persons of any resident concerns.The facility will stress on pre-admission contact, the facility no smoking policy with potential residents and or their family. Offers of assistance for a cessation program will be explained in conjunction with their primary care physician. After admission, residents who chose to violate the polciy will be addressed with family/resident meetings to review policy and resident expectations. Care plans will be modified to the extent possible to accomodate resident wishes and preferences to smoke safely.All smokers assessments were reviewed. Care plans were revised if necessary. The facility will continue to do smoking assessments on admission and review quarterly and PRN by the care plan team. Nursing administration will update the nurse aide assignment sheets daily as needed to assure that staff is aware of any changes to resident plan of care with specifics related to smoking.The DON will monitor for compliance	

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	155631	A. BUILDING 00 B. WING	06/30/2011

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	assistance." The care plan did not address the resident's smoking. During interview the facility Administrator on 6/29/11 at 10:00 A.M., she indicated the resident had been admitted after the smoking policy was changed; however, he had been accidentally told he could smoke at facility outside in the smoke hut, so had been allowed to smoke on facility property. During interview with the ADON on 6/29/11 at 11:10 A.M., she indicated the resident went down the side street this past week to a yard sale off facility property. The sign out form indicated he had signed himself out on 6/25/11 and was gone from 9:15 A.M. to 10:15 A.M. The ADON and SS (Social Service) Director, at this same time, indicated they had not been aware of the resident going off the property to smoke on the street until yesterday. 3. The Resident Policy Manual, no date, was provided by the Social Services Director on 6/29/11 at 9:00 A.M. The policy indicated "...Smoking- There is only one designated smoking area on the facility property. This is the semi-enclosed area outside the facility family room. This is for residents only.		by reviewing resident smoking assessments, related care plans and noted smoking patterns of new residents three times weekly for the first 30 days after admission, then weekly for 6 months. Negative findings will be reported to the facility QA committee.ADDENDUM: 7/29/2011 Response to letter dated 7/25/2011."For residents who chose to smoke, what interventions will the facility take to ensure that tehy are in a safe location, and what interventions will the facility take to ensure residents who use oxygen are safe while they are smoking?"The facility is non-smoking for all new residents. Grandfathered residents (and the two cited residents) will smoke in the designated area outside the family room of the facility. Residents will be requested to inform us (sign out) when leaving the premises for any reason, including smoking.If a resident continually refuses to abide by facility policy or procedure, the facility will implement changes in a resident's plan of care and/or look for alternative placement in conjunction with the resident and responsible party."How will the facility accommodate the resident's wish to smoke and abide by the policy of not allowing smoking in the facility or on the facility grounds?"The facility is non-smoking. Prospective residents are informed of this	

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	New admissions after 2/1/2011 are not permitted to smoke on the facility property. Some residents will need to have their cigarettes kept at the nursing station for their safety. This will be addressed with the resident and responsible family members. The facility does plan to be completely smoke free. Some residents may require supervision while they are smoking. This means that a responsible family member or staff member must be with the resident when they smoke. These residents will have their cigarettes and lighters kept at the nursing station for safety reasons. Residents will be evaluated at admission or as needed to assess smoking safety status. Residents requiring staff supervision will have designated scheduled smoking times. Designated smoking time will be posted...." The admission packets for Residents B and C were provided from the business office on 6/29/11 at 1:00 P.M. Both residents had signed their own admission paper work on admit to the facility which included the smoking policy. The Immediate Jeopardy that began on 5/22/11 was removed on 6/30/11 when the facility provided a safe place for residents to smoke on facility property, but the noncompliance remained at isolated, no		policy prior to admission. Cessation options will be offered to assist residents or potential residents to stop smoking. If a resident continues to smoke, then facility will assist in finding alternative placement.	

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	actual harm with potential for more than minimal harm, that is not immediate jeopardy, because the facility had not inserviced all employees on the new policy and procedure for smoking. This federal tag relates to Complaint IN00092855. 3.1-45(a)(1) 3.1-45(a)(2)			